



State of Connecticut  
Office of Health Care Access  
CON Determination Form  
Form 2020

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CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

All persons who are requesting a determination as to whether a CON is required for a proposed project must complete this form. Completed forms should be submitted to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	NEW ERA REHABILITATION CENTER INC	
Doing Business As	As Above	
Name of Parent Corporation	New Era Rehab Center	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	3851 Main Street 2nd Floor Bridgeport CT 06606	
Petitioner type (e.g., P for profit and NP for Not for Profit)	P	
Name of Contact person, including title	Ebenezer Kolade MD / C.E.O	CHRISTINA KOLADE D.O MEDICAL DIRECTOR
Contact person's street mailing address	3851 Main Street 2nd Floor Bridgeport CT 06606	Same.
Contact person's phone, fax and e-mail address	203 372 3333 Ckolade@aol.com	cell 845 642 3438

fax 203-374-7515

**SECTION II. GENERAL PROPOSAL INFORMATION**

a. Proposal/Project Title:

Intensive Outpatient Treatment Program.

b. Location of proposal (Town including street address):

3851 Main street, Bridgeport CT 2nd floor.

c. List all the municipalities this project is intended to serve:

Bridgeport, Stratford, Milford, Shelton  
Trumbull, Fairfield.

d. Estimated starting date for the project:

April 2006e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in all the boxes that apply)

E P

- ☐ Acute Care Hospital  
☒ Behavioral Health Provider  
☐ Hospital Affiliate

E P

- ☐ Imaging Center  
☐ Ambulatory Surgery Center  
☐ Other specify):

E P

- ☐ Cancer Center  
☐ Primary Care Clinic

**SECTION III. EXPENDITURE INFORMATION**

a. Estimated Total Capital Expenditure/Cost:

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

New Construction/Renovations	\$ 10,000
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	5,000
Sales Tax	
Delivery & Installation	
<b>Total Capital Expenditure</b>	<b>\$0.00</b>
Fair Market Value of Leased Equipment	

<b>Total Capital Cost</b>	<b>\$0.00</b>
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**Major Medical and/or imaging equipment acquisition:**

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide copy of contract with vendor for medical equipment.

## c. Type of financing or funding source:

- ☒ Operating Funds
 ☐ Lease Financing
 ☐ Conventional Loan  
☐ Charitable Contributions
 ☐ CHEFA Financing
 ☐ Grant Funding  
☐ Funded Depreciation
 ☐ Other (specify):

**SECTION IV. PROPOSAL DESCRIPTION**

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Will you be charging a facility fee?
4. Who is the current population served and who is the target population to be served?
5. Who will be providing the service?
6. Who are the payers of this service?

## SECTION V. AFFIDAVIT

Applicant: New Era rehabilitation centerProject Title: Addition of Intensive outpatient  
Treatment ProgramI, Ebenezer Kolade, MD, CEO  
(Name) (Position - CEO or CFO)of New Era rehab ctr. being duly sworn, depose and state that the  
information provided in this CON Determination form is true and accurate to the best of my  
knowledge, and that New Era rehab ctr complies with the appropriate  
(Facility Name)and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-  
486 and/or 4-181 of the Connecticut General Statutes.Ebenezer Kolade 2/10/06  
Signature DateSubscribed and sworn to before me on February 10, 2006James H. J. J. J.  
Notary Public/Commissioner of Superior CourtMy commission expires: My Commission Expires  
Nov. 30, 2009

STATE OF CONNECTICUT  
Department of Public Health

LICENSE

License No. 0266

Facility for the Care or Treatment of Substance  
Abusive or Dependent Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

New Era Rehabilitation Center, Inc. of Bridgeport, CT, d/b/a New Era Rehabilitation Center, Inc. is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

New Era Rehabilitation Center, Inc. is located at 3851 Main Street, Bridgeport, CT 06606 with:

Ebenezer Adekunle Kolade, MD as Executive Director

The service classification(s) and if applicable, the residential capacities are as follows:

Chemical Maintenance Treatment  
Ambulatory Chemical Detoxification Treatment

This license expires June 30, 2006 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2004. RENEWAL.



*J. Robert Galvin M.D., M.P.H.*

J. Robert Galvin, M.D., M.P.H.,  
Commissioner

## **NEW ERA REHABILITATION CENTER**

**3851 Main St 2<sup>nd</sup> floor**

**Bridgeport, CT 06606**

**Telephone: 203 372-3333**

**Fax: 203 374 -7515**

The proposed Intensive Outpatient Program is an additional program to be added to the existing services at New Era Rehabilitation Center. This will enable us to better serve our clients that are opiod dependent, who are currently treated for their opiod addiction, that are also currently addicted to Alcohol, Cocaine, Benzodiazepines and other stimulants e.g. Methamphetamine. We will also treat clients that are not opiod dependent but are dependent on other substance of abuse listed above.

1. Ambulatory Chemical Detoxification, Chemical Maintenance Treatment attached are, public health licenses held.
2. Out Patient Behavioral Health services (Intensive Out Patient Program)
3. Yes, we will be charging a fee for services
4. The current populations served are Opiod dependant patients who use heroin, morphine, percocet, oxycontin and fentanyl. The intended Intensive Out Patient Program (IOP) will care for patients dependent on stimulants such as cocaine, alcohol, methamphetamines and others.
5. Certified and licensed counselors and physicians
6. The payers of service will include federal and state insurance, private insurance, HMO's and private individual payers.